

(v) "Profit add-on" means an additional payment to providers in addition to allowable costs as an incentive for efficient and economical operation.

(w) "Reasonable allowable costs" means the price a prudent, cost conscious buyer would pay a willing seller for goods or services in an arm's-length transaction, not to exceed the limitations set out in this rule.

(x) "Related party/organization" means that the provider is associated or affiliated with, or has the ability to control, or be controlled by, the organization furnishing the service, facilities, or supplies.

(y) "Routine medical and nonmedical supplies and equipment" includes those items generally required to assure adequate medical care and personal hygiene of patients or residents by providers of like levels of care.

(z) "Unit of service" means all patient or resident care at the appropriate level of care included in the established per diem rate required for the care of a patient or resident for one (1) day (twenty-four (24) hours).

(aa) "Use fee" means the reimbursement provided to fully amortize both principal and interest of allowable debt under the terms and conditions specified in this rule.

405 IAC 1-12-3 Accounting records; retention schedule; audit trail; accrual basis; segregation of accounts by nature of business and by location

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 3. (a) The basis of accounting used under this rule is a comprehensive basis of accounting other than generally accepted accounting principles. However, generally accepted accounting principles shall be followed in the preparation and presentation of all financial reports and all reports detailing proposed change

of provider status transactions, unless otherwise prescribed by this rule.

(b) Each provider must maintain financial records for a period of three (3) years after the date of submission of financial reports to the office. The accrual basis of accounting shall be used in all data submitted to the office except for government operated providers that are otherwise required by law to use a cash system. The provider's accounting records must establish an audit trail from those records to the financial reports submitted to the office.

(c) In the event that a field audit indicates that the provider's records are inadequate to support data submitted to the office and the auditor is unable to complete the audit and issue an opinion, the provider shall be given, in writing, a list of the deficiencies and allowed sixty (60) days from the date of receipt of this notice to correct the deficiencies. In the event the deficiencies are not corrected within the sixty (60) day period, the office shall not grant any rate increase to the provider until the cited deficiencies are corrected and notice is sent to the office by the provider. However, the office may:

- (1) make appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records;
- (2) document such adjustments in a finalized exception report; and
- (3) incorporate such adjustments in prospective rate calculations under section 1(d) of this rule.

(d) Each provider shall submit, upon request by the office, confirmation that all deficiencies and adjustments noted in the field audit final written report have been corrected and are not present in the current period annual financial report. However, if deficiencies and adjustments are not corrected, the office may make appropriate adjustments to current and subsequent cost reports of the provider.

(e) If a provider has business enterprises other than those reimbursed by Medicaid under this rule, the revenues, expenses, and statistical and financial records for such enterprises shall be clearly identifiable from the records of the operations reimbursed by Medicaid. If a field audit establishes that records are not maintained so as to clearly identify Medicaid information, none of the commingled costs shall be recognized

TN 94-007
Supersedes:
None

Approval Date 2/13/95 Effective 7/1/94

as Medicaid allowable costs and the provider's rate shall be adjusted to reflect the disallowance effective as of the date of the most recent rate change.

(f) When multiple facilities or operations are owned by a single entity with a central office, the central office records shall be maintained as a separate set of records with costs and revenues separately identified and appropriately allocated to individual facilities. Each central office entity shall file an annual or historical financial report coincidental with the time period for any type of rate review for any individual facility that receives any central office allocation. Allocation of central office costs shall be reasonable, conform to GAAP, and be consistent between years. Any change of central office allocation bases must be approved by the office prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the office at least ninety (90) days prior to the reporting period to which the change applies. Such costs are allowable only to the extent that the central office is providing services related to patient or resident care and the provider can demonstrate that the central office costs improved efficiency, economy, and quality of recipient care. The burden of demonstration that costs are patient or resident related lies with the provider.

405 IAC 1-12-4 Financial report to office; annual schedule; prescribed form; extensions; penalty for untimely filing

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 4. (a) Each provider shall submit an annual financial report to the office not later than ninety (90) days after the close of the provider's reporting year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within sixty (60) days after the initial certification of a provider. This option may be exercised only one (1) time by a provider. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report.

(b) The provider's annual financial report shall be submitted using forms prescribed by the office. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following as a minimum:

- (1) Patient or resident census data.
- (2) Statistical data.
- (3) Ownership and related party information.
- (4) Statement of all expenses and all income.
- (5) Detail of fixed assets and patient or resident related interest bearing debt.
- (6) Complete balance sheet data.
- (7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period, and on the rate effective date as defined by this rule; private pay charges shall be the lowest usual and ordinary charge.
- (8) Certification by the provider that the data are true, accurate, related to patient or resident care, and that expenses not related to patient or resident care have been clearly identified.
- (9) Certification by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer by the provider, and as such are true and accurate to the best of the preparer's knowledge.

(c) Extension of the ninety (90) day filing period shall not be granted unless the provider substantiates to the office or its representatives circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office or its representatives prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office or its representatives shall review the request for extension and notify the provider of approval or disapproval within ten (10) days of receipt. If the request for extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office or its representatives.

(d) Failure to submit an annual financial report within the time limit required shall result in the following actions:

(1) No rate review requests shall be accepted or acted upon by the office until the delinquent report is received.

(2) When an annual financial report is thirty (30) days past due and an extension has not been granted, the rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the thirtieth day the annual financial report is past due and shall so remain until the first day of the month after the delinquent annual financial report is received by the office. Reimbursement lost as a result of this penalty cannot be recovered by the provider.

TN 98-022
Supersedes:
TN 94-007

MAR 15 1999

Approved _____ Effective _____

405 IAC 1-12-5 New provider; initial financial report to office; criteria for establishing initial interim rates; supplemental report; base rate setting

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 5. (a) Rate requests to establish initial interim rates for a new operation, a new type of certified service, a new type of licensure for an existing group home, or a change of provider status shall be filed by submitting an initial rate request to the office on or before thirty (30) days after notification of the certification date or establishment of a new service or type of licensure. Initial interim rates will be set at the greater of:

- (1) the prior provider's then current rate, if applicable; or
- (2) the fiftieth percentile rates as computed in this subsection.

Initial interim rates shall be effective upon the later of the certification date, the effective date of a licensure change, or the date that a service is established. The fiftieth percentile rates shall be computed on a statewide basis for like levels of care, except as provided in subsection (b), using current rates of all CRF/DD and ICF/MR providers. The fiftieth percentile rates shall be maintained by the office, and a revision shall be made to these rates four (4) times per year effective on April 1, July 1, October 1, and January 1.

(b) If there are fewer than six (6) homes with rates established that are licensed as developmental training homes, the fiftieth percentile rate for developmental training homes shall be computed on a statewide basis using current rates of all basic developmental homes with eight and one-half (8 1/2) or fewer hours per patient day of actual staffing. If there are fewer than six (6) homes with rates established that are licensed as small behavior management residences for children, the fiftieth percentile rate for small behavior management residences for children shall be the fiftieth percentile rate for child rearing residences with specialized programs increased by two hundred and forty percent (240%) of the average staffing cost per hour for child rearing residences with specialized programs.

(c) The provider shall file a nine (9) month historical financial report within sixty (60) days following the end of the first nine (9) months of operation. The nine (9) months of historical financial data shall be used to determine the provider's base rate. The base rate shall be effective from the first day of the tenth month of certified operation until the next regularly schedule annual review. An annual financial report need not be submitted until

TN 98-022
Supersedes:
TN 97-007

MAR 15 1999

Approved _____ Effective _____

the provider's first fiscal year end that occurs after the rate effective date of a base rate. In determining the base rate, limitations and restrictions otherwise outlined in this rule, except the annual rate limitation, shall apply. For purposes of this subsection, in determining the nine (9) months of the historical financial report, if the first day of certification falls on or before the fifteenth day of a calendar month, then that calendar month shall be considered the provider's first month of operation. If the first day of certification falls after the fifteenth day of a calendar month, then the immediately succeeding calendar month shall be considered the provider's first month of operation.

(c) The provider's historical financial report shall be submitted using forms prescribed by the office. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following at a minimum:

- (1) Patient or resident census data.
- (2) Statistical data.
- (3) Ownership and related party information.
- (4) Statement of all expenses and all income.
- (5) Detail of fixed assets and patient or resident related interest bearing debt.
- (6) Complete balance sheet data.
- (7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period, and on the rate effective date as defined in this rule; private pay charges shall be the lowest usual and ordinary charge.
- (8) Certification by the provider that:
 - (A) the data are true, accurate, and related to patient or resident care, and
 - (B) expenses not related to patient or resident care have been clearly identified.
- (9) Certification by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer, by the provider, and as such are true and accurate to the best of the preparer's knowledge.

(d) The base rate may be in effect for longer or shorter than twelve (12) months. In such cases, the various applicable limitations shall be proportionately increased or decreased to cover the actual time frame, using a twelve (12) month period as the basis for the computation.

FOOTNOTE TO SECTION 5 (d) ABOVE BUT NOT PART OF THE PROMULGATED

REIMBURSEMENT RULE: THE RATE PERIODS FOR BASE RATES ARE DEFINED AT SECTION 5(b). BASE RATES SHALL BE EFFECTIVE FROM THE FIRST DAY OF THE TENTH MONTH OF CERTIFIED OPERATION UNTIL THE NEXT REGULARLY SCHEDULED ANNUAL REVIEW. THE RATE EFFECTIVE DATE FOR REGULARLY SCHEDULED ANNUAL REVIEWS IS DEFINED AT SECTION 6(a) AS THE FIRST DAY OF THE FOURTH MONTH FOLLOWING THE PROVIDER'S REPORTING YEAR END. BASE RATES MAY BE IN EFFECT FOR LONGER OR SHORTER THAN TWELVE (12) MONTHS IN SITUATIONS WHERE THE BASE RATE EFFECTIVE DATE AS DEFINED IN SECTION 5(a) IS GREATER OR LESS THAN TWELVE (12) MONTHS FROM THE REGULARLY SCHEDULED ANNUAL REVIEW, AS DEFINED IN SECTION 6(a).

(e) The base rate established from the nine (9) months of historical data shall be the rate used for determining subsequent limitations on annual rate adjustments.

(f) Extension of the sixty (60) day filing period shall not be granted unless the provider substantiates to the office circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office shall review the request and notify the provider of approval or disapproval within ten (10) days of receipt. If the extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office.

(g) If the provider fails to submit the nine (9) months of historical financial data within ninety (90) days following the end of the first nine (9) months of operation, and an extension has not been granted, the initial interim

rate shall be reduced by ten percent (10%), effective on the first day of the tenth month after certification and shall so remain until the first day of the month after the delinquent annual financial report is received by the office.

Reimbursement lost because of the penalty cannot be recovered by the provider.

(h) Except as provided in section 17(f) of this rule, neither an initial interim rate nor a base rate shall be established for a provider whose change of provider status was a related party transaction as established in this rule.

(i) The change of provider status shall be rescinded if subsequent transactions by the provider cause a capital lease to be reclassified as an operating lease under the pronouncements adopted in November 1976 by the American Institute of Certified Public Accountants. (Office of the Secretary of Family and Social Services; 405 IAC 1-12-5)

405 IAC 1-12-6 Active providers; rate review; annual request; additional requests due to change in law; request concerning capital return factor; computation of factor

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 6.(a) As a normal practice, the rates shall be reviewed once each year using the annual financial report as the basis of the review. The rate effective date shall be the first day of the fourth month following the provider's reporting year end, provided the annual financial report is submitted within ninety (90) days of the end of the provider's reporting period.

(b) A provider shall not be granted an additional rate review until the review indicated in subsection (a) has been completed. A provider may request no more than one (1) additional rate review during its rate effective year when the provider can reasonably demonstrate the need for a change in rate based on more recent historical data. This additional rate review shall be completed in the same manner as the annual rate review, using all other limitations in effect at the time the annual review took place.

(c) To request the additional review, the provider shall submit, on forms prescribed by the office,

TN 96-006

Supersedes

TN 94-007

Approved 11-29-96 Effective 9-20-96